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Please email or fax this document with a copy of your insurance card to Dr. Humes at least 24 hours prior to first appointment.

NEW MEXICO HEALTH CONNECTIONS INSURANCE RELEASE

Name of Insured:
Policy Number:
Group Number:
Name of Policy:
Amount of Copay:

I give Dr. Humes permission to release the information necessary to file insurance claims and receive payment from NMHC. No other information will be released without my specific authorization.

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Name Date